Pregnancy Massage Therapy Patient Information & Consent

Patient name_____DOB_____ Date_____

How many weeks pregnant are you?_____ Due date_____

How many times have you been pregnant?_____ How many times have you given birth?_____

Are you regularly seeing a physician, nurse-midwife or midwife?_____ Name_____

Emergency contact name_____ Number_____
Relationship to patient_____

In order to provide you with the best care possible during your pregnancy, please check any past or current complications or conditions that may require particular bodywork precautions. Please inform massage therapist of any changes in your pregnancy between visits.

Previous Miscarriages		**Fever**	
Gestational Diabetes		**Skin Disorders**	
Nausea		**Separation of Pubis/Abs**	
Anemia		**Infection (internal or external)**	
Blood Clot		**Varicose Veins**	
Edema/Swelling		**Bed rest/Inactivity**	
Headaches		**High Blood Pressure**	
Back Pain		**Problems with Placenta**	
Leg Cramps		**Pre-term Labor**	
Insomnia		**Baby less active than normal**	
Contagious Disease		**Abdominal Cramping**	
Vaginal Discharge/Bleeding		**Fertility Treatments/Medication**	
High Risk Conditions		**Other**	

If other, please explain:_____
_____
_____

Physician's permission (if needed)_____

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Carlisle, PA 17013
717.243.0307

Any additional information regarding your pregnancy or general health that massage therapist should be aware of?

_____
_____
_____
_____

By signing below, I acknowledge that I have read the above information and consent to Pregnancy Massage Therapy, performed by the massage therapist of SCG Skin Rejuvenation.

Patient _____ Date_____

Witness _____ Date_____

Medical Director_____ Date_____